

<i>SERFF Tracking Number:</i>	<i>MDPC-126061025</i>	<i>State:</i>	<i>District of Columbia</i>
<i>Filing Company:</i>	<i>The Medical Protective Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>09-HCPA-02</i>		
<i>TOI:</i>	<i>11.0 Medical Malpractice - Claims</i>	<i>Sub-TOI:</i>	<i>11.0024 Physicians Assistants</i>
	<i>Made/Occurrence</i>		
<i>Product Name:</i>	<i>Health Care Professionals - Physician Assistants</i>		
<i>Project Name/Number:</i>	<i>NP/PA Filings /09-HCPA-02</i>		

## Filing at a Glance

Company: The Medical Protective Company

Product Name: Health Care Professionals - Physician Assistants      SERFF Tr Num: MDPC-126061025 State: District of Columbia

TOI: 11.0 Medical Malpractice - Claims      SERFF Status: Closed      State Tr Num:

Made/Occurrence

Sub-TOI: 11.0024 Physicians Assistants      Co Tr Num: 09-HCPA-02      State Status:

Filing Type: Rate/Rule      Co Status:      Reviewer(s): Robert Nkojo

Authors: Melissa Coker,      Disposition Date: 07/14/2009

Christopher Cole

Date Submitted: 03/11/2009      Disposition Status: APPROVED

Effective Date Requested (New): 07/01/2009      Effective Date (New):

Effective Date Requested (Renewal): 07/01/2009      Effective Date (Renewal):

State Filing Description:

## General Information

Project Name: NP/PA Filings

Status of Filing in Domicile: Pending

Project Number: 09-HCPA-02

Domicile Status Comments:

Reference Organization: N/A

Reference Number: N/A

Reference Title: N/A

Advisory Org. Circular: N/A

Filing Status Changed: 07/14/2009

State Status Changed:

Deemer Date:

Corresponding Filing Tracking Number: 09-HCPA-02

Filing Description:

The Medical Protective Company is pleased to introduce new Physicians Assistants rates, rules and forms for individual Healthcare Professionals. Where applicable we have separated the forms from the rates and rules and have submitted a separate filing under a separate submission. We respectfully request an effective date of July 1, 2009 for this submission.

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The enclosed Memorandum and exhibits detail the rate development of this filing and provide brief descriptions of the manual rate and rule pages included in the package. In addition to the aforementioned pages, please find specimen copies of the proposed policies and endorsements.

If you should have any additional questions related to this filing, please let me know.

Thank you for your time,  
 Melissa Coker

## Company and Contact

### Filing Contact Information

Melissa Coker, Paralegal melissa.coker@medpro.com  
 5814 Reed Road (260) 486-0838 [Phone]  
 Fort Wayne, IN 46835 (260) 486-0733[FAX]

### Filing Company Information

The Medical Protective Company CoCode: 11843 State of Domicile: Indiana  
 5814 Reed Road Group Code: Company Type:  
 Fort Wayne, IN 46835 Group Name: State ID Number:  
 (260) 486-0838 ext. [Phone] FEIN Number: 35-0506406

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## Filing Fees

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Medical Protective Company	\$0.00		

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## Rate Information

Rate data applies to filing.

<b>Filing Method:</b>	file and use
<b>Rate Change Type:</b>	
<b>Overall Percentage of Last Rate Revision:</b>	
<b>Effective Date of Last Rate Revision:</b>	
<b>Filing Method of Last Filing:</b>	n/a - this is the initial filing

## Company Rate Information

<b>Company Name:</b>	<b>Overall % Indicated Change:</b>	<b>Overall % Rate Impact:</b>	<b>Written Premium Change for this Program:</b>	<b># of Policy Holders Affected for this Program:</b>	<b>Written Premium for this Program:</b>	<b>Maximum % Change (where required):</b>	<b>Minimum % Change (where required):</b>
The Medical Protective Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0024 Physicians Assistants

Made/Occurrence

Product Name: Health Care Professionals - Physician Assistants

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## Rate/Rule Schedule

Review Status:	Exhibit Name:	Rule # or Page #:	Rate Action	Previous State Filing Attachments Number:
	OCC Rate Pages	RTS-xxx; ST-09- New 1		dc occ.pdf
	OCC Class Plan	NPRC-CW; 7/1/2009	New	dc pa oc cp.pdf
	OCC Aggregate Credit Rule	ACR-CW; 7/1/2009	New	dc pa occ agg.pdf
	OCC Deferred Premium Payment Plan Rule	DPP-CW; 7/1/2009	New	dc pa occ dpp.pdf
	OCC Full Time Equivalency Rating Rule	FTE-CW; 7/1/2009	New	dc pa occ fte.pdf
	OCC Group Rating Rule	GRR-CW; 7/1/2009	New	dc pa occ group.pdf
	OCC Leave of Absence Credit Rule	LOA-CW; 7/1/2009	New	dc pa occ loa.pdf
	OCC Military Leave of Absence Credit Rule	MLOA-CW; 7/1/2009	New	dc pa occ mloa.pdf

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OCC Minimum Premium Rating Rule	MPR-CW; 7/1/2009	New	dc pa occ mpr.pdf
OCC Part Time Practice Rule	PTP-CW; 7/1/2009	New	dc pa occ ptp.pdf
OCC Renewal Rating Rule	RRR-CW; 7/1/2009	New	dc pa occ renewal.pdf
OCC Risk Management Credit Rule	RMC-CW; 7/1/2009	New	dc pa occ rmc.pdf
OCC Schedule Rating Plan	SRP-CW; 7/1/2009	New	dc pa occ srp.pdf
OCC Membership Association Credit	MAC-CW; 7/1/2009	New	dc pa occ mac.pdf
OCC New to Practice Credit	NTP-CW; 7/1/2009	New	dc pa occ ntp.pdf
OCC Shared Entity Vicarious Liability Coverage	SVL-CW; 7/1/2009	New	dc pa occ entity.pdf
OCC Partnership or Corporation Coverage	PCC-CW; 7/1/2009	New	dc pa occ pc.pdf
SCM Rate Pages	RTS-xxx; ST-09- New 1		dc scm.pdf

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SCM Class Plan	NPRC-CW; 7/1/2009	New	dc pa cm cp.pdf
SCM Tail Factors	ECF-xxx; ST-09- New 1		dc pa scm ecf.pdf
SCM Aggregate Credit Rule	ACR-CW; 7/1/2009	New	dc pa scm agg.pdf
SCM Deferred Premium Payment Plan Rule	DPP-CW; 7/1/2009	New	dc pa scm dpp.pdf
SCM Full Time Equivalency Rating Rule	FTE-CW; 7/1/2009	New	dc pa scm fte.pdf
SCM Group Rating Rule	GRR-CW; 7/1/2009	New	dc pa scm group.pdf
SCM Leave of Absence Credit Rule	LOA-CW; 7/1/2009	New	dc pa scm loa.pdf
SCM Military Leave of Absence Credit Rule	MLOA-CW; 7/1/2009	New	dc pa scm mloa.pdf
SCM Minimum Premium Rating Rule	MPR-CW; 7/1/2009	New	dc pa scm mpr.pdf
SCM Part Time Practice Rule	PTP-CW; 7/1/2009	New	dc pa scm ptp.pdf

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SCM Renewal Rating Rule	RRR-CW; 7/1/2009	New	dc pa scm renewal.pdf
SCM Risk Management Credit Rule	RMC-CW; 7/1/2009	New	dc pa scm rmc.pdf
SCM Schedule Rating Plan	SRP-CW; 7/1/2009	New	dc pa scm srp.pdf
SCM Membership Association Credit	MAC-CW; 7/1/2009	New	dc pa scm mac.pdf
SCM New to Practice Credit	NTP-CW; 7/1/2009	New	dc pa scm ntp.pdf
SCM Shared Entity Vicarious Liability Coverage	SVL-CW; 7/1/2009	New	dc pa scm shared entity.pdf
SCM Partnership or Corporation Coverage	PCC-CW; 7/1/2009	New	dc pa scm pc.pdf
SCM Accelerated Extension Contract Rule	AEC-CW; 7/1/2009	New	dc pa scm acc.pdf
SCM Extension Contract Rating	ECR-CW; 7/1/2009	New	dc pa scm ecr.pdf
SCM Prior Acts	PAC-CW;	New	dc pa scm prior.pdf

Coverage 7/1/2009

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SCM Slot Rating Rule	SRR-CW; 7/1/2009	New	dc pa scm slot.pdf
SCM Convertible Coverage Rating Plan	CCR-CW; 7/1/2009	New	dc pa scm conv.pdf
OCC Moonlighting Rule	MRR-CW; 7/1/2009	New	dc pa occ moon.pdf
SCM Moonlighting Rule	MRR-CW; 7/1/2009	New	dc pa scm moon.pdf
OCC Student Resident Rule	SRE-CW; 7/1/2009	New	dc pa occ student.pdf

**The  
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**DISTRICT OF COLUMBIA  
PHYSICIAN ASSISTANTS PROGRAM  
OCCURRENCE RATES**

<b>Class</b>	<b>100/300</b>	<b>200/600</b>	<b>250/750</b>	<b>500/1000</b>	<b>1000/6000</b>
<b>P1</b>	2,146	2,897	3,112	3,659	4,507
<b>P2</b>	2,683	3,622	3,890	4,575	5,634
<b>P3</b>	3,219	4,346	4,668	5,488	6,760
<b>PM</b>	697	941	1,011	1,188	1,464
<b>PS</b>	NA	NA	NA	NA	150

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**OCCURRENCE PROGRAM**  
**CLASS PLAN**

**Class P1**

A PHYSICIAN ASSISTANT WHO CARRIES OUT RESPONSIBILITIES GENERALLY PERFORMED BY A QUALIFIED LICENSED PHYSICIAN AND WHO PRACTICES UNDER THE DIRECTION AND SUPERVISION OF A LICENSED PHYSICIAN TO ASSIST THE PHYSICIAN IN THE DIAGNOSTIC MANAGEMENT OF PATIENTS.

**Class P2**

A PHYSICIAN ASSISTANT WHO PRACTICES AS ANY OF THE FOLLOWING:

1. ASSISTING A LICENSED PHYSICIAN WHO IS QUALIFIED TO PERFORM SURGERY – ANY PRACTICE EXPOSURE IN AN OPERATING ROOM OTHER THAN FOR OBSERVATION WITH A GENERAL PRACTITIONER/FAMILY PRACTICE OR GENERAL SURGEON;
2. PRACTICING OR ANY EXPOSURE (10 HOURS A WEEK OR LESS) TO TRAUMA/EMERGENCY ROOM PROCEDURES OR RESPONSIBILITIES;
3. OBSTETRICS PRACTICE OR EXPOSURE LIMITED TO PRENATAL OR POSTNATAL CARE; AND
4. ASSISTING A QUALIFIED LICENSED PHYSICIAN IN ANESTHESIOLOGY.

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**Class P3**

A PHYSICIAN ASSISTANT WHO PRACTICES ANY OF THE FOLLOWING:

1. ASSISTING AN ORTHOPEDIC SURGEON, OB/GYN SURGEON, CARDIOVASCULAR SURGEON AND/OR PLASTIC SURGEON IN SURGERY IN AN OPERATING ROOM OTHER THAN FOR OBSERVATION.
2. PRACTICING OR ANY EXPOSURE (MORE THAN 10 HOURS A WEEK) IN TRAUMA/EMERGENCY ROOM PROCEDURES OR RESPONSIBILITIES;
3. CONTACT OR EXPOSURE WITH OBSTETRICS INCLUDING DELIVERY ROOM RESPONSIBILITIES;
4. CONTACT OR EXPOSURE WITH CARDIAC CATHETERIZATION LABS; AND;
5. ASSISTING IN COSMETIC/AESTHETIC PROCEDURES.

**Class PM**

A PHYSICIAN ASSISTANT WHO QUALIFIES UNDER THE PHYSICIAN ASSISTANT MOONLIGHTING RULE.

**Class PS**

STUDENTS CURRENTLY ENROLLED AND ATTENDING AN AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS APPROVED PHYSICIAN ASSISTANT PROGRAM.

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**AGGREGATE CREDIT RULE**

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE OR MILITARY LEAVE OF ABSENCE CREDITS.

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**DEFERRED PREMIUM PAYMENT PLAN RULE**

THE COMPANY WILL, SUBJECT TO APPLICABLE GUIDELINES, OFFER THE INSURED VARIOUS PREMIUM PAYMENT OPTIONS. THE DEFERRED PREMIUM PAYMENT PLAN REQUIRES A DOWN PAYMENT TO BE PAID ON OR BEFORE THE INCEPTION/RENEWAL DATE OF THE POLICY. THE BALANCE OF THE PREMIUM WILL BE PAYABLE IN PERIODIC INSTALLMENTS. OTHER FEES MAY APPLY.

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**FULL TIME EQUIVALENCY RATING RULE**

COVERAGE FOR A HEALTHCARE PROFESSIONAL GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL INSURED BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH HEALTHCARE PROFESSIONAL'S NUMBER OF HOURS OF PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,000	GROUP PRACTICE
1,800	TRAINING/RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL HEALTHCARE PROFESSIONAL IS .10 (200 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE HEALTHCARE PROFESSIONAL RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE STANDARD RATES.

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**FULL TIME EQUIVALENCY RATING RULE**

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

<u>FTE*</u> <u>PER POLICY</u>	<u>PREMIUM</u> <u>MODIFICATION</u>
1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

\*THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .50 ROUNDING RULE.

PREMIUM MODIFICATION FOR PART TIME PRACTICE, NEW TO PRACTICE, AND RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

FTE POLICIES ARE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS WILL BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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**GROUP RATING RULE**

ANY GROUP PRACTICE CONSISTING OF TWO OR MORE HEALTHCARE PROFESSIONALS MAY BE COLLECTIVELY RATED. "GROUP PRACTICE" SHALL MEAN A GROUP OR BODY OF INSUREDS WHO MAKE A COLLECTIVE BUYING DECISION TO PURCHASE INSURANCE AS THE OWNERS, EMPLOYEES, OR AGENTS OF A SPECIFIC AND DISTINCT CORPORATION, PARTNERSHIP, OR ASSOCIATION.

1. THE PREMIUM FOR THE GROUP WILL BE DETERMINED BY MULTIPLYING THE 'GROUP'S NET PREMIUM' BY ANY CREDITS OR DEBITS ASSIGNED TO THE GROUP UNDER THE SCHEDULE RATING PLAN AFTER FACTORING IN ANY COMMISSION FEE OR OTHER EXPENSE VARIATIONS ASSOCIATED WITH THE GROUP. (THE COMPANY WILL NEGOTIATE AN APPROPRIATE COMMISSION WITH THE INSURED'S AGENT BASED UPON THE GROUP'S SIZE AND THE AMOUNT OF WORK TO BE PERFORMED BY THE AGENT. UPON REQUEST, THE COMPANY WILL WRITE THE GROUP ON A NET OF COMMISSION BASIS IF THE GROUP HAS NEGOTIATED A SEPARATE FEE AGREEMENT WITH ITS AGENT.)
2. THE "GROUP'S NET PREMIUM" WILL EQUAL THE SUM OF THE "INDIVIDUAL NET PREMIUMS" FOR EACH INDIVIDUAL OR ENTITY RECEIVING SEPARATE LIMITS OF LIABILITY.

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**GROUP RATING RULE**

3. THE "INDIVIDUAL NET PREMIUMS" WILL EQUAL THE FILED RATE FOR THE INSURED. HOWEVER, ONCE THE PREMIUM FOR THE GROUP HAS BEEN ESTABLISHED, THE COMPANY MAY ALLOCATE THAT PREMIUM AMONG THE INDIVIDUAL INSURED BASED UPON APPLICABLE UNDERWRITING CRITERIA.

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**LEAVE OF ABSENCE CREDIT RULE**

A HEALTHCARE PROVIDER WHO IS ON A LEAVE OF ABSENCE FOR A CONTINUOUS PERIOD OF 45 DAYS OR MORE MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 100% OF THE APPLICABLE RATE FOR THE PERIOD OF THE LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE, IF REPORTED TO THE COMPANY WITHIN 30 DAYS. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD. LEAVE OF ABSENCE MAY INCLUDE THE FOLLOWING:

- THE BIRTH OF INSURED'S NEWBORN, PLACEMENT OF FOSTER CHILDREN OR INSURED ADOPTS A CHILD, PROVIDED THE LEAVE IS COMPLETED WITHIN 12 MONTHS OF THE BIRTH, PLACEMENT OR ADOPTION.
- TO CARE FOR A SPOUSE, CHILD OR PARENT WHO HAS A SERIOUS HEALTH CONDITION.
- TO CARE FOR INSURED'S OWN HEALTH CONDITION WHICH PREVENTS INSURED FROM WORKING.
- TIME TO ENHANCE THE INSURED'S EDUCATION OR OTHER REASON WHILE NOT PRACTICING.

THIS CREDIT IS NOT AVAILABLE TO AN INSURED'S LEAVE OF ABSENCE FOR VACATION PURPOSES. THE MINIMUM PREMIUM RATING RULE APPLIES TO INSURED'S ELIGIBLE FOR THE LEAVE OF ABSENCE CREDIT.

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**MILITARY LEAVE OF ABSENCE CREDIT RULE**

A HEALTHCARE PROVIDER WHO IS ON A MILITARY LEAVE OF ABSENCE MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 100% OF THE APPLICABLE RATE FOR THE PERIOD OF THE LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE.

THE MINIMUM PREMIUM RATING RULE DOES NOT APPLY TO INSURED THAT ARE ELIGIBLE FOR THE MILITARY LEAVE OF ABSENCE CREDIT.

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**MINIMUM PREMIUM RATING RULE**

ALL POLICIES ARE SUBJECT TO A MINIMUM PREMIUM OF \$50. THE MINIMUM PREMIUM WILL BE RETAINED WHEN THE INSURED REQUESTS CANCELLATION UNLESS THE POLICY IS CANCELLED AS OF THE INCEPTION DATE.

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**PART TIME PRACTICE RULE**

ANY INSURED WHO PRACTICES AN AVERAGE 24 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,250 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE:

AVERAGE NUMBER OF HOURS PRACTICED PER WEEK	0-24
MAX. AGGREGATE HOURS PER YEAR	1,250
CREDIT	35%

NO OTHER CREDITS OR DISCOUNTS ARE TO APPLY CONCURRENT WITH THIS RULE EXCEPT RISK MANAGEMENT CREDIT, MEMBERSHIP ASSOCIATION CREDIT OR SCHEDULE RATING MODIFICATIONS.

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**RENEWAL RATING RULE**

MEMBERS OF A QUALIFIED PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS.

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF \$250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING APPROVAL.

HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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**RISK MANAGEMENT CREDIT RULE**

THE INSURED WILL RECEIVE A TEN PERCENT (10%) PREMIUM CREDIT FOR A RISK MANAGEMENT COURSE APPROVED FOR CREDIT BY THE MEDICAL PROTECTIVE COMPANY.

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**OCCURRENCE PROGRAM**  
**SCHEDULE RATING PLAN**

THE MEDICAL PROTECTIVE COMPANY SHALL UTILIZE THE FOLLOWING SCHEDULE OF MODIFICATIONS TO DETERMINE APPROPRIATE PREMIUMS FOR CERTAIN INSURED, OR GROUPS OF INSURED, WHO IN THE OPINION OF THE MEDICAL PROTECTIVE COMPANY, UNIQUELY QUALIFY FOR SUCH MODIFICATIONS BECAUSE OF FACTORS NOT CONTEMPLATED IN THE FILED RATE STRUCTURE OF THE COMPANY.

THE PREMIUM FOR A RISK MAY BE MODIFIED IN ACCORDANCE WITH THE FOLLOWING, SUBJECT TO A MAXIMUM MODIFICATION OF -25% / 25%; TO RECOGNIZE RISK CHARACTERISTICS THAT ARE NOT REFLECTED IN THE OTHERWISE APPLICABLE PREMIUM. ALL MODIFICATIONS APPLIED UNDER THIS SCHEDULE RATING PLAN ARE SUBJECT TO PERIODIC REVIEW.

THE MODIFICATION SHALL BE BASED ON ONE OR MORE OF THE FOLLOWING CONSIDERATIONS:

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1. **HISTORICAL LOSS EXPERIENCE:**  
THE FREQUENCY OR SEVERITY OF CLAIMS FOR THE INSURED(S) IS GREATER/LESS THAN THE EXPECTED EXPERIENCE FOR AN INSURED(S) OF THE SAME CLASSIFICATION/SIZE OR RECOGNITION OF UNUSUAL CIRCUMSTANCES OF CLAIMS IN THE LOSS EXPERIENCE.
2. **CUMULATIVE YEARS OF PATIENT EXPERIENCE:**  
THE INSURED(S) DEMONSTRATES A GREATER/LESS THAN STABLE LONGSTANDING PRACTICE AND/OR SIGNIFICANT DEGREE OF EXPERIENCE IN THEIR CURRENT AREA OF MEDICINE.
3. **CLASSIFICATION ANOMALIES:**  
CHARACTERISTICS OF A PARTICULAR INSURED THAT DIFFERENTIATE THE INSURED TO BE GREATER/LESS THAN FROM OTHER MEMBERS OF THE SAME CLASS, OR RECOGNITION OF RECENT DEVELOPMENTS WITHIN A CLASSIFICATION OR JURISDICTION THAT ARE ANTICIPATED TO IMPACT FUTURE LOSS EXPERIENCE.

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4. **CLAIM ANOMALIES:**  
ECONOMIC, SOCIETAL OR JURISDICTIONAL CHANGES OR TRENDS THAT WILL POSTIVELY OR NEGATIVELY INFLUENCE THE FREQUENCY OR SEVERITY OF CLAIMS, OR THE UNUSUAL CIRCUMSTANCES OF A CLAIM(S) WHICH UNDERSTATE/OVERSTATE THE SEVERITY OF THE CLAIM(S).
5. **MANAGEMENT CONTROL PROCEDURES:**  
SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.
6. **NUMBER / TYPE OF PATIENT EXPOSURES:**  
SIZE AND/OR DEMOGRAPHICS OF THE PATIENT POPULATION WHICH NEGATIVELY OR POSTIVELY INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.
7. **ORGANIZATIONAL SIZE / STRUCTURE:**  
A GROUP'S SIZE, PROCESSES AND/OR ROSTER OF INSUREDS ARE SUCH THAT THE COMPANY WILL INCUR GREATER OR LESSER COSTS IN ASSOCIATION WITH ITS SERVICE TO, OR COVERAGE OF, THE GROUP.

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8. **HEALTHCARE STANDARDS, QUALITY AND CLAIMS REVIEW:**  
PRESENCE (OR LACK) OF (1) COMMITTEES THAT MEET ON A ROUTINE BASIS TO REVIEW HEALTHCARE PROCEDURES, TREATMENTS, AND PROTOCOLS AND THEN ASSIST IN THE INTEGRATION OF SUCH INTO THE PRACTICE, (2) COMMITTEES THAT MEET TO ASSURE THE QUALITY OF THE HEALTH CARE SERVICES BEING RENDERED AND/OR (3) COMMITTEES TO PROVIDE CONSISTENT REVIEW OF CLAIMS/INCIDENTS THAT HAVE OCCURRED AND TO DEVELOP CORRECTIVE ACTION.
9. **OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:**  
ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.
10. **TRAINING, ACCREDITATION AND CREDENTIALING:**  
THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.
11. **RECORD KEEPING PRACTICES:**  
DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.

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12. **UTILIZATION OF MONITORING EQUIPMENT, DIAGNOSTIC TESTS OR PROCEDURES:**

DEMONSTRATING THE WILLINGNESS (OR LACK THEREOF) TO EXPEND THE TIME AND CAPITAL TO INCORPORATE THE LATEST ADVANCES IN MEDICAL TREATMENTS AND EQUIPMENT INTO THE PRACTICE, PROVIDING ABOVE OR BELOW AVERAGE PROCEDURES AS DEFINED IN UNDERWRITING GUIDELINES FOR A SPECIALTY, OR FAILURE TO MEET ACCEPTED STANDARDS OF CARE.

THE AFOREMENTIONED MODIFICATIONS CONTEMPLATE THE STANDARD ALLOWANCE FOR EXPENSES AND ARE SUBJECT TO THE MAXIMUM MODIFICATION REFERENCED ABOVE. IF THE EXPENSES ARE LESS THAN STANDARD, AN ADDITIONAL MODIFICATION MAY BE MADE TO REFLECT THIS REDUCTION.

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**MEMBERSHIP ASSOCIATION CREDIT**

A PREMIUM CREDIT OF 10% SHALL BE GIVEN TO THOSE INSURED WHO ARE A MEMBER OF A DESIGNATED MEDICAL PROTECTIVE HEALTHCARE PROFESSIONAL ASSOCIATION.

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**NEW TO PRACTICE CREDIT**

A PRACTITIONER IN THEIR FIRST YEAR OF PRACTICE, AFTER GRADUATION, WILL RECEIVE A 25% CREDIT APPLIED TO CURRENT FILED RATES.

THE NEW TO PRACTICE CREDIT WILL NOT BE APPLIED IN COMBINATION WITH PART-TIME CREDITS.

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**SHARED ENTITY VICARIOUS LIABILITY COVERAGE**

A SCHEDULED HEALTHCARE PROFESSIONAL ENTITY MAY BE MADE AN ADDITIONAL INSURED ON A HEALTHCARE PROFESSIONAL'S PRIMARY INDIVIDUAL POLICY AT NO ADDITIONAL CHARGE. COVERAGE IS LIMITED TO VICARIOUS LIABILITY BASED SOLELY ON PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED BY THE NAMED INSURED PHYSICIAN ASSISTANT.

THIS ADDITION WILL NOT OPERATE TO PROVIDE ADDITIONAL LIMITS OF LIABILITY PER CLAIM FILED OR ANNUAL AGGREGATE BEYOND THE STATED LIMITS OF THE INDIVIDUAL POLICY.

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**PARTNERSHIP OR CORPORATION COVERAGE**

THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED HEALTHCARE PROFESSIONALS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION.

LIMITS OF COVERAGE FOR THE PARTNERSHIP OR CORPORATION MAY NOT EXCEED THE LOWEST LIMITS OF COVERAGE OF ANY OF THE INSURED PARTNERS, SHAREHOLDERS, OR EMPLOYED/CONTRACTED HEALTHCARE PROFESSIONALS.

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**0 YEARS SINCE RETROACTIVE DATE**

<b>Class</b>	<b>100/300</b>	<b>200/600</b>	<b>250/750</b>	<b>500/1000</b>	<b>1000/6000</b>
<b>P1</b>	782	1,056	1,134	1,333	1,642
<b>P2</b>	978	1,320	1,418	1,667	2,054
<b>P3</b>	1,173	1,584	1,701	2,000	2,463
<b>PM</b>	634	856	919	1,081	1,331
<b>PS</b>					

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**STANDARD CLAIMS MADE RATES**

**1 YEAR SINCE RETROACTIVE DATE**

<b>Class</b>	<b>100/300</b>	<b>200/600</b>	<b>250/750</b>	<b>500/1000</b>	<b>1000/6000</b>
<b>P1</b>	1,485	2,005	2,153	2,532	3,119
<b>P2</b>	1,856	2,506	2,691	3,164	3,898
<b>P3</b>	2,227	3,006	3,229	3,797	4,677
<b>PM</b>	634	856	919	1,081	1,331
<b>PS</b>					

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**2 YEARS SINCE RETROACTIVE DATE**

<b>Class</b>	<b>100/300</b>	<b>200/600</b>	<b>250/750</b>	<b>500/1000</b>	<b>1000/6000</b>
<b>P1</b>	1,912	2,581	2,772	3,260	4,015
<b>P2</b>	2,390	3,227	3,466	4,075	5,019
<b>P3</b>	2,867	3,870	4,157	4,888	6,021
<b>PM</b>	634	856	919	1,081	1,331
<b>PS</b>					

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**MATURE**

<b>Class</b>	<b>100/300</b>	<b>200/600</b>	<b>250/750</b>	<b>500/1000</b>	<b>1000/6000</b>
<b>P1</b>	1,951	2,634	2,829	3,326	4,097
<b>P2</b>	2,439	3,293	3,537	4,158	5,122
<b>P3</b>	2,926	3,950	4,243	4,989	6,145
<b>PM</b>	634	856	919	1,081	1,331
<b>PS</b>					

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**CLASS PLAN**

**Class P1**

A PHYSICIAN ASSISTANT WHO CARRIES OUT RESPONSIBILITIES GENERALLY PERFORMED BY A QUALIFIED LICENSED PHYSICIAN AND WHO PRACTICES UNDER THE DIRECTION AND SUPERVISION OF A LICENSED PHYSICIAN TO ASSIST THE PHYSICIAN IN THE DIAGNOSTIC MANAGEMENT OF PATIENTS.

**Class P2**

A PHYSICIAN ASSISTANT WHO PRACTICES AS ANY OF THE FOLLOWING:

1. ASSISTING A LICENSED PHYSICIAN WHO IS QUALIFIED TO PERFORM SURGERY – ANY PRACTICE EXPOSURE IN AN OPERATING ROOM OTHER THAN FOR OBSERVATION WITH A GENERAL PRACTITIONER/FAMILY PRACTICE OR GENERAL SURGEON;
2. PRACTICING OR ANY EXPOSURE (10 HOURS A WEEK OR LESS) TO TRAUMA/EMERGENCY ROOM PROCEDURES OR RESPONSIBILITIES;
3. OBSTETRICS PRACTICE OR EXPOSURE LIMITED TO PRENATAL OR POSTNATAL CARE; AND
4. ASSISTING A QUALIFIED LICENSED PHYSICIAN IN ANESTHESIOLOGY.

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**CLASS PLAN**

**Class P3**

A PHYSICIAN ASSISTANT WHO PRACTICES ANY OF THE FOLLOWING:

1. ASSISTING AN ORTHOPEDIC SURGEON, OB/GYN SURGEON, CARDIOVASCULAR SURGEON AND/OR PLASTIC SURGEON IN SURGERY IN AN OPERATING ROOM OTHER THAN FOR OBSERVATION.
2. PRACTICING OR ANY EXPOSURE (MORE THAN 10 HOURS A WEEK) IN TRAUMA/EMERGENCY ROOM PROCEDURES OR RESPONSIBILITIES;
3. CONTACT OR EXPOSURE WITH OBSTETRICS INCLUDING DELIVERY ROOM RESPONSIBILITIES;
4. CONTACT OR EXPOSURE WITH CARDIAC CATHETERIZATION LABS; AND;
5. ASSISTING IN COSMETIC/AESTHETIC PROCEDURES.

**Class PM**

A PHYSICIAN ASSISTANT WHO QUALIFIES UNDER THE PHYSICIAN ASSISTANT MOONLIGHTING RULE.

**Class PS**

STUDENTS CURRENTLY ENROLLED AND ATTENDING AN AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS APPROVED PHYSICIAN ASSISTANT PROGRAM.

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**EXTENSION CONTRACT RATING FACTORS**

<b>YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE</b>	<b>FACTOR</b>
LESS THAN 1	0.730
1	1.160
2	1.400
MATURE	1.750

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**AGGREGATE CREDIT RULE**

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE OR MILITARY LEAVE OF ABSENCE CREDITS.

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**DEFERRED PREMIUM PAYMENT PLAN RULE**

THE COMPANY WILL, SUBJECT TO APPLICABLE GUIDELINES, OFFER THE INSURED VARIOUS PREMIUM PAYMENT OPTIONS. THE DEFERRED PREMIUM PAYMENT PLAN REQUIRES A DOWN PAYMENT TO BE PAID ON OR BEFORE THE INCEPTION/RENEWAL DATE OF THE POLICY. THE BALANCE OF THE PREMIUM WILL BE PAYABLE IN PERIODIC INSTALLMENTS. OTHER FEES MAY APPLY.

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**FULL TIME EQUIVALENCY RATING RULE**

COVERAGE FOR A HEALTHCARE PROFESSIONAL GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL INSURED BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH HEALTHCARE PROFESSIONAL'S NUMBER OF HOURS OF PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,000	GROUP PRACTICE
1,800	TRAINING/RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL HEALTHCARE PROFESSIONAL IS .10 (200 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE HEALTHCARE PROFESSIONAL RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE STANDARD RATES.

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**FULL TIME EQUIVALENCY RATING RULE**

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

<u>FTE*</u> <u>PER POLICY</u>	<u>PREMIUM</u> <u>MODIFICATION</u>
1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

\*THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .50 ROUNDING RULE.

PREMIUM MODIFICATION FOR PART TIME PRACTICE, NEW TO PRACTICE, AND RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

FTE POLICIES ARE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS WILL BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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**GROUP RATING RULE**

ANY GROUP PRACTICE CONSISTING OF TWO OR MORE HEALTHCARE PROFESSIONALS MAY BE COLLECTIVELY RATED. ("GROUP PRACTICE" SHALL MEAN A GROUP OR BODY OF INSURED'S WHO MAKE A COLLECTIVE BUYING DECISION TO PURCHASE INSURANCE AS THE OWNERS, EMPLOYEES, OR AGENTS OF A SPECIFIC AND DISTINCT CORPORATION, PARTNERSHIP, OR ASSOCIATION.)

1. THE PREMIUM FOR THE GROUP WILL BE DETERMINED BY MULTIPLYING THE 'GROUP'S NET PREMIUM" BY ANY CREDITS OR DEBITS ASSIGNED TO THE GROUP UNDER THE SCHEDULE RATING PLAN AFTER FACTORING IN ANY COMMISSION FEE OR OTHER EXPENSE VARIATIONS ASSOCIATED WITH THE GROUP. (THE COMPANY WILL NEGOTIATE AN APPROPRIATE COMMISSION WITH THE INSURED'S AGENT BASED UPON THE GROUP'S SIZE AND THE AMOUNT OF WORK TO BE PERFORMED BY THE AGENT. UPON REQUEST, THE COMPANY WILL WRITE THE GROUP ON A NET OF COMMISSION BASIS IF THE GROUP HAS NEGOTIATED A SEPARATE FEE AGREEMENT WITH ITS AGENT.)
2. THE "GROUP'S NET PREMIUM" WILL EQUAL THE SUM OF THE "INDIVIDUAL NET PREMIUMS" FOR EACH INDIVIDUAL OR ENTITY RECEIVING SEPARATE LIMITS OF LIABILITY.

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**GROUP RATING RULE**

3. THE "INDIVIDUAL NET PREMIUMS" WILL EQUAL THE FILED RATE FOR THE INSURED. HOWEVER, ONCE THE PREMIUM FOR THE GROUP HAS BEEN ESTABLISHED, THE COMPANY MAY ALLOCATE THAT PREMIUM AMONG THE INDIVIDUAL INSURED BASED UPON APPLICABLE UNDERWRITING CRITERIA.

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**LEAVE OF ABSENCE CREDIT RULE**

A HEALTHCARE PROVIDER WHO IS ON A LEAVE OF ABSENCE FOR A CONTINUOUS PERIOD OF 45 DAYS OR MORE MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 100% OF THE APPLICABLE RATE FOR THE PERIOD OF THE LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE, IF REPORTED TO THE COMPANY WITHIN 30 DAYS. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD. LEAVE OF ABSENCE MAY INCLUDE THE FOLLOWING:

- THE BIRTH OF INSUREDS NEWBORN, PLACEMENT OF FOSTER CHILDREN OR INSURED ADOPTS A CHILD, PROVIDED THE LEAVE IS COMPLETED WITHIN 12 MONTHS OF THE BIRTH, PLACEMENT OR ADOPTION.
- TO CARE FOR A SPOUSE, CHILD OR PARENT WHO HAS A SERIOUS HEALTH CONDITION.
- TO CARE FOR INSUREDS OWN HEALTH CONDITION WHICH PREVENTS INSURED FROM WORKING.
- TIME TO ENHANCE THE INSUREDS EDUCATION OR OTHER REASON WHILE NOT PRACTICING.

THIS CREDIT IS NOT AVAILABLE TO AN INSUREDS LEAVE OF ABSENCE FOR VACATION PURPOSES. THE MINIMUM PREMIUM RATING RULE APPLIES TO INSUREDS ELIGIBLE FOR THE LEAVE OF ABSENCE CREDIT.

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**MILITARY LEAVE OF ABSENCE CREDIT RULE**

A HEALTHCARE PROVIDER WHO IS ON A MILITARY LEAVE OF ABSENCE MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 100% OF THE APPLICABLE RATE FOR THE PERIOD OF THE LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE.

THE MINIMUM PREMIUM RATING RULE DOES NOT APPLY TO INSUREDS THAT ARE ELIGIBLE FOR THE MILITARY LEAVE OF ABSENCE CREDIT.

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**MINIMUM PREMIUM RATING RULE**

ALL POLICIES ARE SUBJECT TO A MINIMUM PREMIUM OF \$50. THE MINIMUM PREMIUM WILL BE RETAINED WHEN THE INSURED REQUESTS CANCELLATION UNLESS THE POLICY IS CANCELLED AS OF THE INCEPTION DATE.

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**PART TIME PRACTICE RULE**

ANY INSURED WHO PRACTICES ON AVERAGE 24 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,250 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE:

AVERAGE NUMBER OF HOURS PRACTICED PER WEEK	0-24
MAX. AGGREGATE HOURS PER YEAR	1,250
CREDIT	35%

NO OTHER CREDITS OR DISCOUNTS ARE TO APPLY CONCURRENT WITH THIS RULE EXCEPT RISK MANAGEMENT CREDIT, MEMBERSHIP ASSOCIATION CREDIT OR SCHEDULE RATING.

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**PART TIME PRACTICE RULE**

THE PART TIME PRACTICE CREDIT WILL NOT BE APPLIED TO THE EXTENSION CONTRACT RATING UNLESS THE PART TIME PRACTICE DID NOT EXCEED AN AVERAGE OF 1,250 HOURS/YEAR OVER THE PREVIOUS FIVE CONSECUTIVE POLICY YEARS WITH THE COMPANY.

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**RENEWAL RATING RULE**

MEMBERS OF A QUALIFIED PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS.

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF \$250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING APPROVAL.

HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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**RISK MANAGEMENT CREDIT RULE**

THE INSURED WILL RECEIVE A TEN PERCENT (10%) PREMIUM CREDIT FOR A RISK MANAGEMENT COURSE APPROVED FOR CREDIT BY THE MEDICAL PROTECTIVE COMPANY.

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**STANDARD CLAIMS MADE PROGRAM**  
**SCHEDULE RATING PLAN**

THE MEDICAL PROTECTIVE COMPANY SHALL UTILIZE THE FOLLOWING SCHEDULE OF MODIFICATIONS TO DETERMINE APPROPRIATE PREMIUMS FOR CERTAIN INSURED, OR GROUPS OF INSURED, WHO IN THE OPINION OF THE MEDICAL PROTECTIVE COMPANY, UNIQUELY QUALIFY FOR SUCH MODIFICATIONS BECAUSE OF FACTORS NOT CONTEMPLATED IN THE FILED RATE STRUCTURE OF THE COMPANY.

THE PREMIUM FOR A RISK MAY BE MODIFIED IN ACCORDANCE WITH THE FOLLOWING, SUBJECT TO A MAXIMUM MODIFICATION OF -25% / 25% ; TO RECOGNIZE RISK CHARACTERISTICS THAT ARE NOT REFLECTED IN THE OTHERWISE APPLICABLE PREMIUM. ALL MODIFICATIONS APPLIED UNDER THIS SCHEDULE RATING PLAN ARE SUBJECT TO PERIODIC REVIEW.

THE MODIFICATION SHALL BE BASED ON ONE OR MORE OF THE FOLLOWING CONSIDERATIONS:

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**DISTRICT OF COLUMBIA**  
**HEALTHCARE PROFESSIONALS**  
**PHYSICIANS ASSISTANTS**  
**STANDARD CLAIMS MADE PROGRAM**  
**SCHEDULE RATING PLAN**

1. **HISTORICAL LOSS EXPERIENCE:**

THE FREQUENCY OR SEVERITY OF CLAIMS FOR THE INSURED(S) IS GREATER/LESS THAN THE EXPECTED EXPERIENCE FOR AN INSURED(S) OF THE SAME CLASSIFICATION/SIZE OR RECOGNITION OF UNUSUAL CIRCUMSTANCES OF CLAIMS IN THE LOSS EXPERIENCE.

2. **CUMULATIVE YEARS OF PATIENT EXPERIENCE:**

THE INSURED(S) DEMONSTRATES A GREATER/LESS THAN STABLE LONGSTANDING PRACTICE AND/OR SIGNIFICANT DEGREE OF EXPERIENCE IN THEIR CURRENT AREA OF MEDICINE.

3. **CLASSIFICATION ANOMALIES:**

CHARACTERISTICS OF A PARTICULAR INSURED THAT DIFFERENTIATE THE INSURED TO BE GREATER/LESS THAN FROM OTHER MEMBERS OF THE SAME CLASS, OR RECOGNITION OF RECENT DEVELOPMENTS WITHIN A CLASSIFICATION OR JURISDICTION THAT ARE ANTICIPATED TO IMPACT FUTURE LOSS EXPERIENCE.

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**SCHEDULE RATING PLAN**

4. **CLAIM ANOMALIES:**  
ECONOMIC, SOCIETAL OR JURISDICTIONAL CHANGES OR TRENDS THAT WILL POSTIVELY OR NEGATIVELY INFLUENCE THE FREQUENCY OR SEVERITY OF CLAIMS, OR THE UNUSUAL CIRCUMSTANCES OF A CLAIM(S) WHICH UNDERSTATE/OVERSTATE THE SEVERITY OF THE CLAIM(S).
5. **MANAGEMENT CONTROL PROCEDURES:**  
SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.
6. **NUMBER/TYPE OF PATIENT EXPOSURES:**  
SIZE AND/OR DEMOGRAPHICS OF THE PATIENT POPULATION WHICH NEGATIVELY OR POSTIVELY INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.
7. **ORGANIZATIONAL SIZE/STRUCTURE:**  
A GROUP'S SIZE, PROCESSES AND/OR ROSTER OF INSUREDS ARE SUCH THAT THE COMPANY WILL INCUR GREATER OR LESSER COSTS IN ASSOCIATION WITH ITS SERVICE TO, OR COVERAGE OF, THE GROUP.

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8. **HEALTHCARE STANDARDS, QUALITY AND CLAIMS REVIEW:**  
PRESENCE (OR LACK) OF (1) COMMITTEES THAT MEET ON A ROUTINE BASIS TO REVIEW HEALTHCARE PROCEDURES, TREATMENTS, AND PROTOCOLS AND THEN ASSIST IN THE INTEGRATION OF SUCH INTO THE PRACTICE, (2) COMMITTEES THAT MEET TO ASSURE THE QUALITY OF THE HEALTH CARE SERVICES BEING RENDERED AND/OR (3) COMMITTEES TO PROVIDE CONSISTENT REVIEW OF CLAIMS/INCIDENTS THAT HAVE OCCURRED AND TO DEVELOP CORRECTIVE ACTION.
9. **OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:**  
ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.
10. **TRAINING, ACCREDITATION AND CREDENTIALING:**  
THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.
11. **RECORD KEEPING PRACTICES:**  
DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.

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12. **UTILIZATION OF MONITORING EQUIPMENT, DIAGNOSTIC TESTS OR PROCEDURES:**

DEMONSTRATING THE WILLINGNESS (OR LACK THEREOF) TO EXPEND THE TIME AND CAPITAL TO INCORPORATE THE LATEST ADVANCES IN MEDICAL TREATMENTS AND EQUIPMENT INTO THE PRACTICE, PROVIDING ABOVE OR BELOW AVERAGE PROCEDURES AS DEFINED IN UNDERWRITING GUIDELINES FOR A SPECIALTY, OR FAILURE TO MEET ACCEPTED STANDARDS OF CARE.

THE AFOREMENTIONED MODIFICATIONS CONTEMPLATE THE STANDARD ALLOWANCE FOR EXPENSES AND ARE SUBJECT TO THE MAXIMUM MODIFICATION REFERENCED ABOVE. IF THE EXPENSES ARE LESS THAN STANDARD, AN ADDITIONAL MODIFICATION MAY BE MADE TO REFLECT THIS REDUCTION.

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**STANDARD CLAIMS MADE PROGRAM**  
**MEMBERSHIP ASSOCIATION CREDIT**

A PREMIUM CREDIT OF 10% SHALL BE GIVEN TO THOSE INSUREDS WHO ARE A MEMBER OF A DESIGNATED MEDICAL PROTECTIVE HEALTHCARE PROFESSIONAL ASSOCIATION.

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**STANDARD CLAIMS MADE PROGRAM**  
**NEW TO PRACTICE CREDIT**

A PRACTITIONER IN THEIR FIRST YEAR OF PRACTICE, AFTER GRADUATION, WILL RECEIVE A 25% CREDIT APPLIED TO CURRENT FILED RATES.

THE NEW TO PRACTICE CREDIT WILL NOT BE APPLIED IN COMBINATION WITH PART-TIME CREDITS.

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**STANDARD CLAIMS MADE PROGRAM**  
**SHARED ENTITY VICARIOUS LIABILITY COVERAGE**

A SCHEDULED HEALTHCARE PROFESSIONAL ENTITY MAY BE MADE AN ADDITIONAL INSURED ON A HEALTHCARE PROFESSIONAL'S PRIMARY INDIVIDUAL POLICY AT NO ADDITIONAL CHARGE. COVERAGE IS LIMITED TO VICARIOUS LIABILITY BASED SOLELY ON PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED BY THE NAMED INSURED PHYSICIAN ASSISTANT.

THIS ADDITION WILL NOT OPERATE TO PROVIDE ADDITIONAL LIMITS OF LIABILITY PER CLAIM FILED OR ANNUAL AGGREGATE BEYOND THE STATED LIMITS OF THE INDIVIDUAL POLICY.

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**STANDARD CLAIMS MADE PROGRAM**  
**PARTNERSHIP OR CORPORATION COVERAGE**

THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED HEALTHCARE PROFESSIONALS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION.

LIMITS OF COVERAGE FOR THE PARTNERSHIP OR CORPORATION MAY NOT EXCEED THE LOWEST LIMITS OF COVERAGE OF ANY OF THE INSURED PARTNERS, SHAREHOLDERS, OR EMPLOYED/CONTRACTED HEALTHCARE PROFESSIONALS.

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**STANDARD CLAIMS MADE PROGRAM**  
**ACCELERATED EXTENSION CONTRACT RULE**

THE COMPANY MAY AGREE TO WAIVE THE STANDARD REQUIREMENTS FOR QUALIFYING FOR A FREE EXTENDED REPORTING PERIOD ENDORSEMENT AT RETIREMENT IF THE INSURED MEETS THE FOLLOWING CRITERIA:

- 1) THE INSURED IS A MEMBER OF A GROUP PRACTICE THAT IS INSURED ON A CLAIMS-MADE BASIS WITH THE COMPANY.
- 2) THE GROUP REQUESTED THE WAIVE FOR AN INSURED WHO ANTICIPATES PERMANENTLY RETIRING FROM THE PRACTICE OF MEDICINE IN LESS THAN ONE YEAR AND/OR WILL NOT ATTAIN THE REQUIRED NUMBER OF YEARS OF CONTINUOUS CLAIMS-MADE COVERAGE AT THE TIME OF RETIREMENT.
- 3) THE INSURED OTHERWISE MEETS THE REQUIREMENTS AS SET FORTH IN THE POLICY FOR A FREE EXTENSION CONTRACT.
- 4) THE COMPANY APPROVED THE GROUP'S REQUEST FOR THE WAIVER AFTER DETERMINING THE INSURED HAD LIMITED PRIOR ACTS EXPOSURE.

THE TOTAL NUMBER OF INSUREDS WITHIN A GROUP PRACTICE THAT MAY QUALIFY FOR THIS WAIVER MAY NOT EXCEED A RATIO OF 1 IN 3.

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**STANDARD CLAIMS MADE PROGRAM**  
**EXTENSION CONTRACT RATING**

THE PREMIUM FOR THE EXTENSION CONTRACT ENDORSEMENT SHALL BE DETERMINED BY APPLYING THE EXTENSION CONTRACT RATING FACTORS CONTAINED IN THE RATES SECTION OF THIS MANUAL TO THE APPLICABLE STANDARD MATURE CLAIMS MADE RATE, SUBJECT TO EXPIRING PART-TIME AND SCHEDULE RATING MODIFICATIONS.

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**STANDARD CLAIMS MADE PROGRAM**  
**PRIOR ACTS COVERAGE**

THE POLICY SHALL BE EXTENDED TO PROVIDE PRIOR ACTS COVERAGE IN ACCORDANCE WITH THE APPLICABLE RETROACTIVE DATE(S). THE RETROACTIVE DATE CAN BE ADVANCED ONLY WITH THE WRITTEN ACKNOWLEDGEMENT OF THE INSURED AND THE APPROVAL BY THE COMPANY.

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**STANDARD CLAIMS MADE PROGRAM**  
**SLOT RATING RULE**

COVERAGE FOR MULTI-HEALTHCARE PROFESSIONAL GROUPS IS AVAILABLE, AT THE COMPANY'S OPTION, ON A SLOT BASIS RATHER THAN ON AN INDIVIDUAL HEALTHCARE PROFESSIONAL BASIS. THE SLOT ENDORSEMENT WILL IDENTIFY THE INDIVIDUALS AND PRACTICE SETTINGS THAT ARE COVERED. COVERAGE WILL BE PROVIDED ON A SHARED LIMIT BASIS FOR THOSE INSURED MOVING THROUGH THE SLOT OR POSITION.

THE APPLICABLE MANUAL RATE WILL BE DETERMINED BY THE CLASSIFICATION OF THE SLOT. POLICIES CONVERTED TO A SLOT BASIS WILL BE RATED AS A STANDARD CLAIMS MADE POLICY, UTILIZING THE RETROACTIVE DATE OF THE SLOT. EXTENSION CONTRACT COVERAGE MAY BE PURCHASED FOR THE SLOT BASED ON THE APPLICABLE RETROACTIVE DATE, CLASSIFICATION AND LIMITS.

PREMIUM MODIFICATIONS FOR PART TIME PRACTICE AND RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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**STANDARD CLAIMS MADE PROGRAM**  
**CONVERTIBLE COVERAGE RATING PLAN**

INSUREDS SHALL BE PROVIDED THE OPTION, SUBJECT TO UNDERWRITING GUIDELINES, TO CONVERT FROM STANDARD CLAIMS MADE TO OCCURRENCE COVERAGE. THE INSURED SHALL BE ELIGIBLE FOR CONVERSION AFTER THE FOLLOWING CONDITIONS HAVE BEEN MET:

- 1) PAYMENT TO THE COMPANY OF THE APPLICABLE PREMIUM FOR A MINIMUM OF THREE ANNUAL STANDARD CLAIMS MADE POLICIES.
- 2) ACHIEVE THREE YEARS OF CONTINUOUS CLAIMS MADE COVERAGE UNDER THIS PLAN WITH NO CLAIMS ATTRIBUTED TO THE INSURED.
  - A CLAIM UNDER THIS PLAN SHALL NOT BE CONSTRUED TO INCLUDE INSTANCES OF MISTAKEN IDENTITY, BLANKET DEFENDANT LISTINGS, IMPROPER INCLUSION, OR NON-MERITORIOUS OR FRIVOLOUS CLAIMS.

AT THE TIME THE AFOREMENTIONED CONDITIONS ARE MET, AND THE INSURED ELECTS TO PURCHASE OCCURRENCE COVERAGE, THE COMPANY WILL ISSUE AN EXTENSION CONTRACT, COVERING SERVICES SUBSEQUENT TO THE RETROACTIVE DATE AND PRIOR TO THE EXPIRATION OF THE CLAIMS MADE POLICY, AND WILL WAIVE ANY PREMIUM THAT WOULD NORMALLY BE DUE FOR SUCH EXTENSION.

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**STANDARD CLAIMS MADE PROGRAM**

**CONVERTIBLE COVERAGE RATING PLAN**

THE APPLICABLE PREMIUM UNDER THIS PLAN SHALL BE EQUAL TO 100% OF THE MANUAL PREMIUM THAT WOULD OTHERWISE BE DERIVED FOR THE INSURED UNDER THE OCCURRENCE PROGRAM. NO OTHER MODIFICATIONS ARE TO APPLY CONCURRENT WITH THIS RULE WITH THE EXCEPTION OF MEMBERSHIP, RISK MANAGEMENT AND SCHEDULE RATING MODIFICATIONS.

SHOULD THE INSURED BE UNABLE TO MEET THE CONDITIONS FOR CONVERSION, THE INSURED MAY ELECT TO PURCHASE AN EXTENSION CONTRACT SUBJECT TO POLICY PROVISIONS. REFER TO THE EXTENSION CONTRACT RATING RULE TO DETERMINE THE APPLICABLE PREMIUM.

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**OCCURRENCE PROGRAM**  
**MOONLIGHTING RATING RULE**

ANY HEALTHCARE PROFESSIONAL WHO REQUESTS COVERAGE FOR MOONLIGHTING ACTIVITIES, WHILE WORKING FULL TIME AT A PRACTICE EXCLUDED BY THE MEDICAL PROTECTIVE COMPANY, AND AVERAGES LESS THAN 500 HOURS DURING THE TERM OF AN ANNUAL POLICY FOR SUCH MOONLIGHTING ACTIVITIES, WILL BE CONSIDERED A MOONLIGHTING PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

THE RATE SHALL BE CALCULATED AS 0.325 OF THE APPLICABLE STATE/TERRITORY OCCURRENCE CLASS P1 RATE. THE PREMIUM SHALL BE FULLY EARNED AT THE INCEPTION DATE OF THE POLICY.

TO QUALIFY, THE MOONLIGHTING PRACTITIONER MUST BE CLAIM FREE FOR A MINIMUM OF THE PRECEDING FIVE YEARS. PART TIME APPLICANTS OR INSURED ARE NOT ELIGIBLE FOR MOONLIGHTING COVERAGE.

THE COMPANY, AT OUR DISCRETION, MAY AUDIT THE PRACTITIONER TO VERIFY COMPLIANCE WITH THE TERMS OF THIS MOONLIGHTING RULE.

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**STANDARD CLAIMS MADE PROGRAM**  
**MOONLIGHTING RATING RULE**

ANY HEALTHCARE PROFESSIONAL WHO REQUESTS COVERAGE FOR MOONLIGHTING ACTIVITIES, WHILE WORKING FULL TIME AT A PRACTICE EXCLUDED BY THE MEDICAL PROTECTIVE COMPANY, AND AVERAGES LESS THAN 500 HOURS DURING THE TERM OF AN ANNUAL POLICY FOR SUCH MOONLIGHTING ACTIVITIES, WILL BE CONSIDERED A MOONLIGHTING PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

THE RATE SHALL BE CALCULATED AS 0.325 OF THE APPLICABLE STATE/TERRITORY MATURE CLAIMS MADE CLASS P1 RATE. THE PREMIUM SHALL BE FULLY EARNED AT THE INCEPTION DATE OF THE POLICY.

TO QUALIFY, THE MOONLIGHTING PRACTITIONER MUST BE CLAIM FREE FOR A MINIMUM OF THE PRECEDING FIVE YEARS. PART TIME APPLICANTS OR INSUREDS ARE NOT ELIGIBLE FOR MOONLIGHTING COVERAGE.

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**STANDARD CLAIMS MADE PROGRAM**  
**MOONLIGHTING RATING RULE**

UPON TERMINATION OF THE MOONLIGHTING POLICY, EXCEPT DUE TO NON-PAYMENT OF PREMIUM, THE INSURED MAY REQUEST IN WRITING, WITHIN 60 DAYS OF THE TERMINATION DATE, A REPORTING ENDORSEMENT. THE COMPANY WILL WAIVE ANY PREMIUM THAT WOULD NORMALLY BE DUE FOR SUCH EXTENSION.

THE COMPANY, AT OUR DISCRETION, MAY AUDIT THE PRACTITIONER TO VERIFY COMPLIANCE WITH THE TERMS OF THIS MOONLIGHTING RULE.

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**OCCURRENCE PROGRAM**  
**STUDENT/RESIDENT RATING RULE**

RESTRICTED COVERAGE IS AVAILABLE FOR HEALTHCARE PROFESSIONAL STUDENTS AND RESIDENTS AT THE FOLLOWING RATE:

SPECIALTY	TYPE	RATE (ANNUAL)
PHYSICIAN ASSISTANT	STUDENT/RESIDENT	\$150

NO OTHER CREDITS OR DEBITS SHALL APPLY WITH THIS RATING PROGRAM EXCEPT FOR SCHEDULE RATING MODIFICATIONS.

<i>SERFF Tracking Number:</i>	<i>MDPC-126061025</i>	<i>State:</i>	<i>District of Columbia</i>
<i>Filing Company:</i>	<i>The Medical Protective Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>09-HCPA-02</i>		
<i>TOI:</i>	<i>11.0 Medical Malpractice - Claims</i>	<i>Sub-TOI:</i>	<i>11.0024 Physicians Assistants</i>
	<i>Made/Occurrence</i>		
<i>Product Name:</i>	<i>Health Care Professionals - Physician Assistants</i>		
<i>Project Name/Number:</i>	<i>NP/PA Filings /09-HCPA-02</i>		

## Supporting Document Schedules

	<b>Review Status:</b>	
<b>Satisfied -Name:</b>	Cover Letter All Filings	03/04/2009
<b>Comments:</b>	Please find cover letter attached	
<b>Attachment:</b>	dc coverletter.pdf	

	<b>Review Status:</b>	
<b>Satisfied -Name:</b>	Consulting Authorization	03/04/2009
<b>Comments:</b>	n/a - this company is being made by the company	

	<b>Review Status:</b>	
<b>Satisfied -Name:</b>	Actuarial Certification (P&C)	03/04/2009
<b>Comments:</b>	Please find attached the DC Memo and Exhibits.	
<b>Attachments:</b>	dc pa ex.pdf DC PA Memo.pdf	

	<b>Review Status:</b>	
<b>Satisfied -Name:</b>	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)	03/04/2009
<b>Comments:</b>	This is an initial filing.	

	<b>Review Status:</b>	
<b>Satisfied -Name:</b>	District of Columbia and Countrywide Loss Ratio Analysis (P&C)	03/04/2009
<b>Comments:</b>		

<i>SERFF Tracking Number:</i>	<i>MDPC-126061025</i>	<i>State:</i>	<i>District of Columbia</i>
<i>Filing Company:</i>	<i>The Medical Protective Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>09-HCPA-02</i>		
<i>TOI:</i>	<i>11.0 Medical Malpractice - Claims</i>	<i>Sub-TOI:</i>	<i>11.0024 Physicians Assistants</i>
	<i>Made/Occurrence</i>		
<i>Product Name:</i>	<i>Health Care Professionals - Physician Assistants</i>		
<i>Project Name/Number:</i>	<i>NP/PA Filings /09-HCPA-02</i>		

**This is an initial filing.**





March 11, 2009

Department of Insurance and Security Regulations  
Insurance Products Division  
810 First Street, NE, Room 701  
Washington, DC 20002

**RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843  
COMPANY FILE NO: 09-HCPA-02  
COMPANY FEIN NO: 35-0506406  
DISTRICT OF COLUMBIA HEALTHCARE PROFESSIONALS – PHYSICIAN ASSISTANTS  
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS  
INITIAL RATE FILING  
INITIAL RULE FILING**

**PROPOSED EFFECTIVE DATE: July 1, 2009**

Dear Sir or Madame:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate and rule filing applicable to its District of Columbia Healthcare Professionals – Physician Assistant product. The company requests **July 1, 2009**, as the effective date for this submission.

The enclosed Memorandum and exhibits detail the rate development of this filing and provide brief descriptions of the manual rate and rule pages included in the package. In addition to the aforementioned pages, please find specimen copies of the proposed policies and endorsements.

Should you have any questions regarding this filing, please do not hesitate to contact me. Thank you.

Sincerely,

Melissa Coker Millican, Paralegal  
The Medical Protective Company  
5814 Reed Road  
Fort Wayne, IN 46835-3568  
(800)-348-4669, ext. 6838  
(260)-486-0733 (fax)  
melissa.millican@medpro.com

Enclosure(s)

**THE MEDICAL PROTECTIVE COMPANY  
DC**

**EXHIBIT I  
Determination of Indicated Rate  
PHYSICIAN ASSISTANTS PROFESSIONAL LIABILITY**

	(1)	(2)	(3)=(2)/(1)	(4)	(5)=(3)x(4)	(6)
Accident Year	CLEP (000's)	Ultimate LLAE (000's)	Ultimate LLAE Ratio	Trend Factor @ 2.0%	Trended LLAE Ratio	Weight (6)=(1)/(1 Total)
1997	4,514	2,536	0.562	1.294	0.727	0.17
1998	5,751	3,097	0.538	1.268	0.683	0.21
1999	5,746	2,311	0.402	1.244	0.500	0.21
2000	6,367	2,836	0.445	1.219	0.543	0.24
2001	4,681	2,830	0.605	1.195	0.723	0.17
Total	27,057	13,609			0.625	1.00

(1) Weighted Average Ultimate Trended Loss and LAE Ratio	62.5%
(2) Target Loss and LAE Ratio	56.5%
(3) Indicated Rate Level Change	10.7%
(4) Selected Rate Level Change	2.0%
(5) Indicated Rate = Current Program Class N1, Mature Claims Made Rate x [1.0 + (4)]	2,118
(6) Med Pro Proposed Rate	1,951

**NOTES:**

- (1) Current Level Earned Premiums have been on-leveled to reflect the current rates for the Lexington/Granite State Insurance Companies.
- (3) From Exhibit II.
- (6) Weights in proportion to exposures (CLEP).

**THE MEDICAL PROTECTIVE COMPANY  
DC**

**EXHIBIT II  
Determination of Ultimate LLAE Ratios  
PHYSICIAN ASSISTANTS PROFESSIONAL LIABILITY**

COUNTRYWIDE	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)=(6)/(1)
Accident Year	CLEP (000's)	Reported Incurred LAE (000's)	Loss Development Factors	Incurred LDF Ultimates	Bornhuetter- Ferguson Ultimates	Selected Ultimates	Ultimate LLAE ULAE = 2.1%	Ultimate LLAE Ratio
1997	4,514	2,187	1.136	2,484		2,484	2,536	0.562
1998	5,751	2,634	1.151	3,033		3,033	3,097	0.538
1999	5,746	1,507	1.502	2,264		2,264	2,311	0.402
2000	6,367	983	2.625	2,581	2,898	2,777	2,836	0.445
2001	4,681	634	6.702	4,249	2,513	2,772	2,830	0.605
Total	27,057	7,945					13,609	0.503

**NOTES:**     ## The a-priori LAE ratio is the sum of all prior years selected ultimates divided by all prior years CLEP.

**THE MEDICAL PROTECTIVE COMPANY  
DC**

**EXHIBIT III  
Incurred Loss Development - Countrywide  
PHYSICIAN ASSISTANTS PROFESSIONAL LIABILITY**

	<b>Incurred LALE</b>									
	<b>12</b>	<b>24</b>	<b>36</b>	<b>48</b>	<b>60</b>	<b>72</b>	<b>84</b>	<b>96</b>	<b>108</b>	<b>120</b>
1992	2,075	4,071	5,209	5,304	5,182	5,143	5,335	5,340	5,375	5,407
1993	167	298	701	1,050	1,056	1,065	1,080	1,199	1,206	
1994	-	32	1,244	1,515	1,662	1,560	1,686	1,758		
1995	-	432	597	1,352	1,181	1,737	2,533			
1996	39	128	279	454	657	566				
1997	225	804	1,326	2,087	2,187					
1998	547	875	1,680	2,634						
1999	136	536	1,507							
2000	7	983								
2001	634									

	<b>12 to 24</b>	<b>24 to 36</b>	<b>36 to 48</b>	<b>48 to 60</b>	<b>60 to 72</b>	<b>72 to 84</b>	<b>84 to 96</b>	<b>96 to 108</b>	<b>108 to 120</b>
1992	1,962	1,280	1,018	0,977	0,992	1,037	1,001	1,007	1,006
1993	1,784	2,352	1,498	1,006	1,009	1,014	1,110	1,006	
1994	-	38,875	1,218	1,097	0,939	1,081	1,043		
1995	-	1,382	2,265	0,874	1,471	1,458			
1996	3,282	2,180	1,627	1,447	0,861				
1997	3,573	1,649	1,574	1,048					
1998	1,600	1,920	1,568						
1999	3,941	2,812							
2000	140,429								

	<b>12 to 24</b>	<b>24 to 36</b>	<b>36 to 48</b>	<b>48 to 60</b>	<b>60 to 72</b>	<b>72 to 84</b>	<b>84 to 96</b>	<b>96 to 108</b>	<b>108 to 120</b>
All Years	22,367	6,556	1,538	1,075	1,054	1,148	1,051	1,006	1,006
All Year Excl HI	2,078	2,049	1,497	1,032	0,980	1,059			
All Year Wtd	2,553	1,748	1,304	1,014	1,034	1,119	1,024	1,006	
Latest 3	48,656	2,127	1,590	1,123	1,090	1,184	1,051		
Latest 3 Wtd	3,470	2,037	1,575	1,034	1,104	1,215	1,024		
Latest 5	30,565	1,988	1,650	1,094	1,054				
Latest 5 Wtd	3,486	1,942	1,569	1,044	1,034				

	<b>2001</b>	<b>2000</b>	<b>1999</b>	<b>1998</b>	<b>1997</b>	<b>1996</b>	<b>1995</b>	<b>1994</b>	<b>1993</b>
Selected	2,553	1,748	1,304	1,014	1,034	1,059	1,024	1,006	1,006
Cumulative	6,702	2,625	1,502	1,151	1,136	1,098	1,037	1,012	1,006

**SOURCE:** Loss data is from a Granite State Insurance Company Rate Filing in New York.  
Department File Number R200300926.

**THE MEDICAL PROTECTIVE COMPANY  
DC**

**EXHIBIT IV  
National Practitioner Data Bank - Trend  
PHYSICIAN ASSISTANTS**

<b>COUNTRYWIDE</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>
<b>NPDB Year</b>	<b>Total Paid Indemnity</b>	<b>Paid Counts</b>	<b>Paid Severity</b>
1999	9,526,250	73	130,497
2000	8,852,050	69	128,291
2001	12,057,800	71	169,828
2002	16,720,000	108	154,815
2003	24,689,650	102	242,055
2004	22,843,500	123	185,720
2005	17,359,750	90	192,886
2006	22,012,500	94	234,176
2007	13,253,800	79	167,770
			<u>Trend</u>
		1999-2007	5.6%
		2000-2007	4.7%
		2001-2007	2.0%
		<b>Selected:</b>	<b>2.0%</b>

**THE MEDICAL PROTECTIVE COMPANY  
DC**

**EXHIBIT V  
Expenses  
PHYSICIAN ASSISTANTS**

<b>Expenses</b>	<b>Percent</b>
(1) Commissions	30.0%
(2) Taxes Licenses & Fees	2.5%
(3) General Expenses	5.0%
(4) Profit & Contingencies	5.0%
(5) Total	42.5%
(6) Unallocated Loss Adjustment Expense	1.8%
(7) Permissible Loss Ratio	56.5%

THE MEDICAL PROTECTIVE COMPANY

DISTRICT OF COLUMBIA

HEALTHCARE PROFESSIONALS  
PHYSICIAN ASSISTANTS

ACTUARIAL MEMORANDUM

The Medical Protective Company (MedPro) respectfully submits support for its new Physician Assistants Product. The attached exhibits support rates for a stand alone physician assistants product in the District of Columbia. The proposed rates represent a new product available to the thousands of Physicians Assistants who do not have their professional liability insurance provided by their primary physicians practice or hospital. The proposed effective date for the new product is July 01, 2009.

Our filing is based on the most recent publicly available countrywide Physician Assistant data from the Granite State Insurance Company. It is Med Pro's understanding that this market has been subsequently rolled from Granite State Insurance Company to the Lexington Insurance Company where it is being written on a surplus lines basis.

**EXHIBIT I: DETERMINATION OF INDICATED RATE**

Exhibit I shows the historical loss experience of the product prior to being rolled into the surplus lines market. The indicated rate based on historical ultimate losses and trend is displayed on line 5 and the final selected rate is displayed on line 6.

**EXHIBIT II: DETERMINATION OF ULTIMATE LLAE RATIOS**

The exhibit shows the calculation of the ultimate losses and loss expenses (LLAE) underlying the Physician Assistant's product. The resulting ultimate LLAE ratio is carried forward to Exhibit I and used to derive the indicated pure premium underlying the Physician Assistant rate.

**EXHIBIT III: INCURRED LOSS DEVELOPMENT**

The exhibit displays the historical loss and allocated loss expenses by development period and the corresponding age to age development factors. The selected development factors are carried forward to Exhibit II to determine ultimate losses.

**EXHIBIT IV: Trend**

The exhibit displays the Physician Assistant indemnity payments and counts from the National Practitioner Databank. The corresponding severities are used to calculate a range of indicated trends. The selected trend is carried forward to Exhibit I.

## **EXHIBIT V: Expenses**

The exhibit displays the expenses underlying the proposed Med Pro rates. The permissible loss and loss adjustment expense ratio was carried forward to Exhibit I and used in determining the indicated rate change.

## **RATE PAGES**

The rate pages for the Physician Assistant Product are enclosed for your review.

## **REVISED MANUAL RULES**

The Medical Protective Company proposes the following rating rules which conform to the countrywide template and largely do not constitute a substantive change in use or content from most rules currently on file for other Medical Protective Products.

### **ACCELERATED EXTENSION CONTRACT RULE**

The Company proposes to file an Accelerated Extension Contract Rule for its Standard Claims Made Program. If requirements outlined in the rule are met, the insured may qualify for an Accelerated Extension Contract. The total number of insureds within a group practice that may qualify should not exceed a ratio of one in three. There is no rate impact associated with this rule.

### **AGGREGATE CREDIT RULE**

The Company proposes to file an Aggregate Credit Rule for its Occurrence and Standard Claims Made Programs. This rule outlines the limitation of all credits shall not exceed 50%, with the exception of Part Time, Leave of Absence or Military Leave of Absence credits. This rule conforms with the countrywide format.

### **CONVERTIBLE CLAIMS MADE RATING RULE**

The Company proposes to file the Convertible Claims Made Rating Plan for its Standard Claims Made Program. This rule outlines the conditions on which an insured would be eligible to convert a Standard Claims Made policy to an Occurrence policy at no charge. This rule conforms with the countrywide format.

### **DEFERRED PAYMENT PLAN RULE**

The Company wishes to file the Deferred Payment Plan Rule for its Occurrence and Standard Claims Made Programs. This plan requires a down payment to be paid on or before the inception/renewal date of the policy. There is no rate impact associated with this rule.

### **EXTENSION CONTRACT RATING**

The Company proposes to file an Extension Contract Rating Rule for its Standard Claims Made Program to clarify the modifications employed in the extension contract premium calculation. This rule is consistent with our countrywide format.

### **FULL TIME EQUIVALENCY RATING RULE**

The Company proposes to file the Full Time Equivalency Rating Rule for its Occurrence and Standard Claims Made Programs. This rule outlines rating for coverage for a multi-provider groups which is available, at the Company's option, on a full time equivalent (FTE) basis rather than on an individual healthcare provider basis. This rule is consistent with our countrywide format.

### **GROUP RATING RULE**

The Company proposes to file the Group Rating Rule for its Occurrence and Standard Claims Made Programs. The rule outlines the methodology in which a group of two or more healthcare professionals will be rated. The rule also outlines how premium will be allocated to each member within such group. This rule conforms with the countrywide format.

### **LEAVE OF ABSENCE CREDIT RULE**

The Company proposes to file the Leave of Absence Credit Rule for its Occurrence and Standard Claims Made Programs. The rule provides rating for those insureds which have a "continuous" leave of absence of 45 days. This rule is consistent with our countrywide format.

### **MEMBERSHIP ASSOCIATION CREDIT RULE**

The Company wishes to revise the Membership Association Credit Rule for its Occurrence and Standard Claims Made Programs. This rule allows for a premium modification, due to unique characteristics of a healthcare practice and their membership in qualified professional associations. The rule is consistent with the countrywide format.

### **MILITARY LEAVE OF ABSENCE CREDIT RULE**

The Company proposes to file the Military Leave of Absence Credit Rule for its Occurrence and Standard Claims Made Programs. The rule provides rating for those insureds which are on active military leave. This rule is consistent with our countrywide format.

### **MINIMUM PREMIUM RULE**

The Company wishes to file the Minimum Premium Rule for its Occurrence and Standard Claims Made Programs. This rule requires a minimum policy premium of \$50, is consistent with the countrywide format, and does not present a substantive rate impact.

### **MOONLIGHTING RATING RULE**

The Company wishes to file the Moonlighting Rating Rule for its Occurrence and Standard Claims Made Programs. This rule outlines the rating methodology that will be employed when providing coverage for moonlighting activities. This rule conforms with the countrywide template.

### **NEW TO PRACTICE CREDIT RULE**

The Company proposes to file the New to Practice Credit for the Occurrence and Standard Claims Made Programs. The revisions include explicitly limiting the application of this credit to those healthcare providers that are starting their practice for the first time. The rule is consistent with the countrywide format.

### **PARTNERSHIP OR CORPORATION COVERAGE RULE**

The Company proposes to file a Partnership or Corporation Rating Rule for the Occurrence and Standard Claims Made Programs. The rule outlines that such coverage shall be calculated as 10% of the individual insureds premium. This rule is consistent with our countrywide format.

### **PART TIME PRACTICE RULE**

The Company wishes to file a Part Time Practice Rule for its Occurrence and Standard Claims Made Programs. This rule provides for a 35% credit for insureds working 24 hours or less per week. This rule is consistent with our countrywide format.

### **PRIOR ACTS COVERAGE**

The Company proposes to file the Prior Acts Coverage Rule for its Standard Claims Made Program. This rule outlines rating for prior acts coverage and clarifies that the advancement of the retroactive date can only be completed with not only the written acknowledgement of the insured, but also with the approval of the Company. This rule is consistent with the countrywide format.

### **RENEWAL RATING RULE**

The Company wishes to file the Renewal Rating Rule for its Occurrence and Standard Claims Made Programs. This rule outlines the conditions on which a group's premium, which exceeds \$250,000, may be held constant from policy year to policy year. This rule conforms with our countrywide format.

### **RISK MANAGEMENT CREDIT RULE**

The Company proposes to file a Risk Management Credit Rule for its Occurrence and Standard Claims Made Programs. This rule explains that a 10% credit is available to the policyholder for approved Risk Management courses, and follows the countrywide format.

### **SCHEDULE RATING PLAN**

The Company proposes to file a Schedule Rating Plan rule for its Occurrence and Standard Claims Made Programs. The proposed rule allows for a rate modification for the recognition of unique risk characteristics not contemplated in the company's filed rate structure.

The proposed rule also provides additional clarity regarding the characteristics underlying each criteria as well as modifications necessary as a result of reduction in expenses. The rule conforms to the Medical Protective Company's countrywide template.

### **SHARED ENTITY VICARIOUS LIABILITY COVERAGE**

The Company proposes to file a Shared Entity Vicarious Liability Coverage rating rule for its Occurrence & Standard Claims Made Programs. This rule outlines the methodology for adding an additional insured to the policy, for VL exposure only, on a shared limit basis. This rule conforms with the Company's countrywide format.

### **SLOT RATING RULE**

The Company proposes to file a Slot Rating Rule for its Standard Claims Made Program. This rule outlines and identifies that coverage for multi-healthcare provider groups is available, at the Company's option, on a slot basis rather than on an individual healthcare provider basis. The slot endorsement will identify the individuals and practice settings that are covered. This rule conforms to the countrywide format.

### **STUDENT RESIDENT RATING RULE**

The Company wishes to file the Student Resident Rating Rule for its Occurrence Program. This rule outlines the rating methodology for a Student/Resident at the reduced coverage. This rule conforms with our countrywide format.